

INTERMEDIATE SUICIDE PREVENTION SAFETY PLANNING

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This breakout will build upon the foundations laid in “Basic Safety Planning”, identifying ways to tailor safety plans for different treatment settings and populations and promote safety plans as a dynamic intervention.

Objectives:

1. Identify ways to make safety planning a more robust, collaborative, dynamic intervention
2. Learn to tie safety planning to differing levels of suicide risk
3. Learn considerations for different treatment settings and populations

Safety planning SAVES LIVES

COMPARED TO NO-SUICIDE CONTRACTS:

- Stanley, Brown, Brenner, et al (2018)
 - Individuals who safety planned in the ED were half as likely to exhibit suicidal behavior and twice as likely to present for outpatient MH appointments
- Zonana, Simberlund & Christos (2018)
 - Safety plans reduce suicidal behavior, increase crisis call use and decrease hospitalizations
- Gamarra, Luciano, Gradus, et al (2015)
 - Veterans with higher quality safety plans are less likely to be hospitalized in the year after safety planning

Craig Bryan, PsyD at NCVS with Military samples

- Bryan, Mintz, Clemans, et al. (2017) – Impact on SI & behavior
 - Both attempts and ideation were reduced for those with safety plans as compared to CFS (Contract for Safety)
- Bryan, Mintz, Clemans, et al. (2018) – Impact on mood and hospitalizations
 - Safety Planning linked to reductions in negative and increases in positive emotions
 - Enhanced safety planning (i.e., includes Reasons for Living) was linked to a decrease in psychiatric hospitalization
- Bryan, May, Rozek, et al (2018) – Those who made and used safety plans were more likely to recall behavioral coping strategies and less likely to be hospitalized

Giving credit where credit is due

- The evidence-base for suicide prevention safety planning has been anchored by the work of Gregory Brown, PhD & Barbara Stanley, PhD, disseminated at the VA by Wendy Batdorf, PhD as well as the Rocky Mountain MIRECC
- **SINCERE THANKS** for these clinicians training others in suicide prevention safety planning as an **INTERVENTION** that can be **STANDARDIZED**
- Several of the slides in this presentation are used with permission from the VA Advanced Training in the Safety Planning Intervention (ASPI) Program
 - For more information about the ASPI Program, please visit <http://suicidesafetyplan.com/>
 - This presentation is not intended to replace or substitute the intensive didactic and experiential training provided in the ASPI program. Additional competency-based training is recommended to obtain the necessary skills to implement this intervention. This presentation alone does not provide equivalent training to the EBP training programs.

Sections of a SAFETY PLAN

CRISIS NARRATIVE followed by:

1. Triggers/Risk Factors/Warning signs
2. Internal Coping Strategies
3. Social contacts & Settings to Distract
4. Family or friends who can help
5. Professionals/VCL
6. Making the environment safe
7. Reasons for Living

Patient Safety Plan Template

Step 1: Writing your thoughts, images, mood, situation, behavior that a crisis may be developing

1. ...think about things about past traumatic life events
2. ...medication, over-the-counter prescription, OTC, over-the-counter
3. ...Major life events, family health issues that can trigger my PTSD

Step 2: Internal coping strategies: Things I can do to take my mind off my problems without contacting another person (meditation, techniques, physical activities)

1. Prepare a low-carb homemade meal & give friends over
2. Go for a walk & listen to my favorite tunes
3. Create hand art

Step 3: People and social settings that provide distraction

1. Name: Pia / Andie	Phone: [redacted]
2. Name: Coffee & Book Store / Library	Phone: [redacted]
3. Name: Chikadee Cultural Center / New Reading	Phone: [redacted]

Step 4: People whom I can ask for help

1. Name: Sophia	Phone: [redacted]
2. Name: Jennifer	Phone: [redacted]
3. Name: Christopher	Phone: [redacted]

Step 5: Professionals or agencies I can contact during a crisis

1. Clinician Name: [redacted]	Phone: [redacted]
2. Clinician Name: [redacted]	Phone: [redacted]
3. Local Urgent Care Services: [redacted]	Urgent Care Services Address: [redacted]
4. Suicide Prevention Lifeline: 1-800-273-TALK (8255)	

Step 6: Making the environment safe

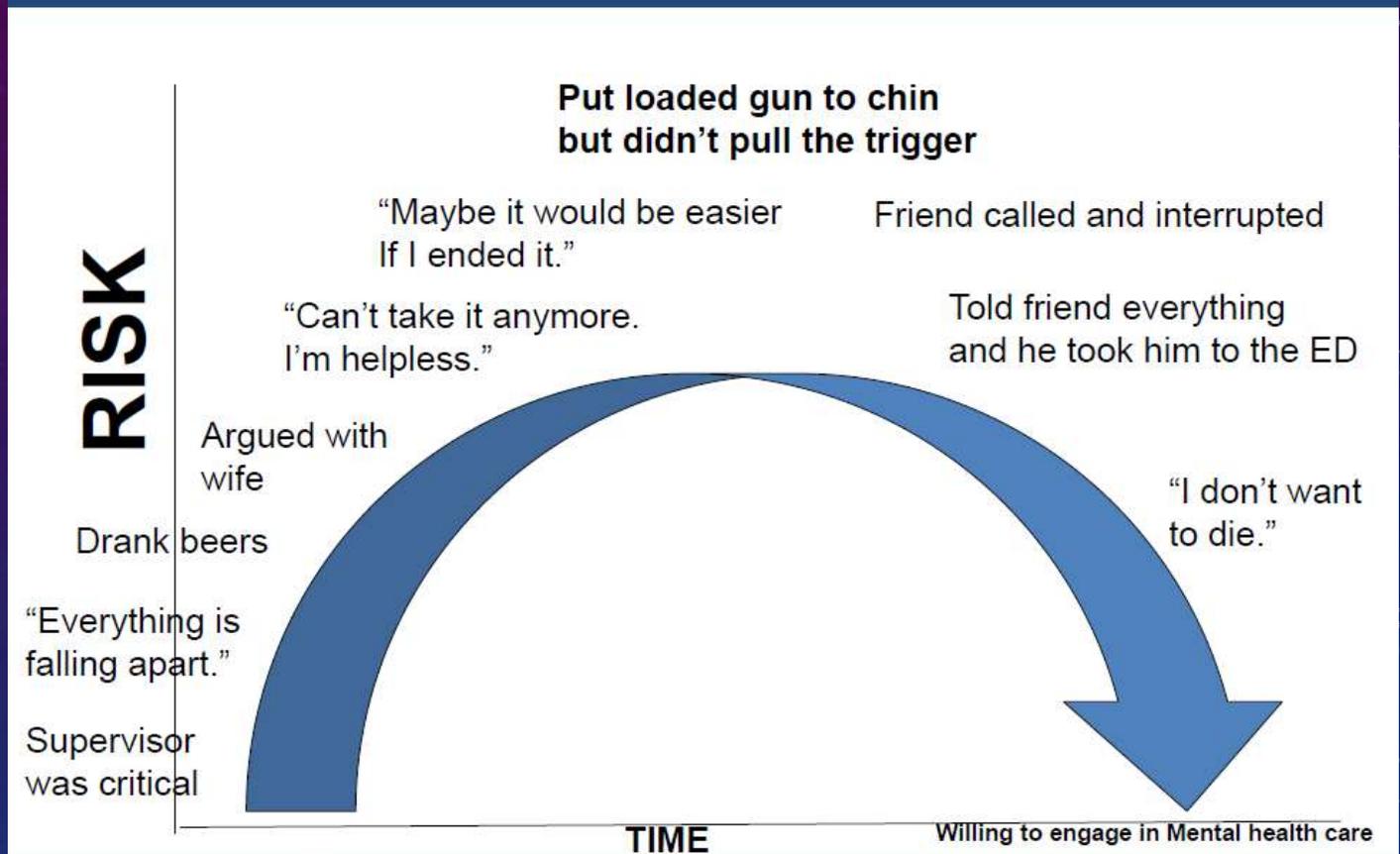
1. Always dispose of leftover prescription medications
2. Limit exposure to negative/toxic people. Keep relationships healthy

The one thing that is most important to me and worth living for in:
Family - I want to honor my family & be a good ancestor for my descendants.

Suicide as a solution to a problem

- Suicide can often be thought of a solution to an impossible problem/set of problems
- Individuals who are thinking of suicide are strongly influenced by their emotions (see Linehan, 1993):
 - Emotion-focused coping
 - Narrowing of attention
 - Impulsivity
- Underlying problems and dilemmas **MUST** get treated in MH treatment; safety planning buys time

Suicide Risk Curve: Case Example



FROM Brown,
Stanley &
Batdorf (April
2020)

COLLABORATION is key

- Veteran can feel alone and embarrassed
 - Normalize
 - Offer empathy & support
- Clinician takes an active approach at each step of the process
 1. Explains rationale for the step
 2. Brainstorms ideas with the client but let them offer choices first
 3. Assesses feasibility and addresses road-blocks
- Take time out and turn toward the client
- Pen & paper and then using the computer can help here

Quality & Completeness



- Remember the notion of S.M.A.R.T. goals when making safety plans
- More detail is better:
 - Identified coping strategies
 - Specific support people
 - Making sure listed telephone numbers and addresses are current
- Takes about 20-30 minutes

Educating the client

- Suicidal urges spike and subside
- Efforts to soothe/distract on one's on can be a boost to confidence
- “Ratchet” up the plan as needed
- Asking for help is a sign of strength
 - We all need help sometimes
 - Pay it forward?

Easy to read & easy to follow

- Use the patients own words
- Hand-written works well
 - Index cards
 - Safety plan templates
- Guide Veteran to follow the steps until suicidal crisis subsides
 - If one section is not helpful, go to the next step
 - Remind that they can certainly reach out for support at any time
- Use **VIEW PURPOSE** & **TIPs** suggestions throughout the template

COMPLETING THE PLAN is only the BEGINNING

- Clarify importance
- Revisit the plan & check on usage

Wrapping up the plan

- Review the plan with the Veteran and assess how likely s/he is to use it
 - Problem-solve barriers to using the plan
 - Assign homework? (e.g., using a particular strategy; adding more to the plan)
- Discuss where the Veteran will keep the plan (on phone?)
- Make sure the Veteran gets a copy
- Set a date to review the plan

Using the Safety Plan as a THERAPEUTIC TOOL

- Following-up with safety plans makes a difference
- Updating Safety Plans is a start but not the end
- We want our patient to USE and DEVELOP their plan
 - Ask about the last time they used their plan and where they keep it
 - Check regularly if there are any changes that they would like to make to their plan
 - **KEY: Major changes to the client's life warrant safety plan review and update** Examples?

Safety Plan review

1. Do you remember the last Safety Plan you developed?
2. Have you actually used your Safety Plan?
3. Was the plan helpful?
4. How can we revise the plan to make it even more useful?

Review of the plan becomes a regular facet of in & out of session MH recovery work

Reviewing unused safety plans

- Shame, guilt, and embarrassment can be severe for suicidal individuals
- Isolation, withholdings and minimization of problems can be present
- **GOAL: Normalize difficulties/inability to use the plan and then work to trouble-shoot roadblocks:**
 - Are warning signs noticeable?
 - Is plan accessible/visible?
 - Are friends/family apprised and involved?
 - **Other barriers to use?**

ASSESS SUICIDE RISK

- Stratify suicide risk
- Plan and intervene based on findings

Gauge safety planning on risk

Prior to safety planning, assess & stratify suicide risk:

- **ACUTE** vs. **CHRONIC**
- **Low** → **Intermediate** → **High**
- Columbia-Suicide Severity Rating Scale (C-SSRS) & Beck Scale for Suicide Ideation (SSI) are well-supported measures to start

C-SSRS

1. Over the past month, have you wished you were dead or wished you could go to sleep and not wake up?
 Yes *Proceed to question #2 regardless of response.*
 No
2. Over the past month, have you had any actual thoughts of killing yourself?
 Yes *If 'Yes', proceed to question #3*
 No *If 'No', proceed to question #7*
3. Over the past month, have you been thinking about how you might do this?
 Yes
 No *Proceed to question #4 regardless of response.*
4. Over the past month, have you had these thoughts and had some intention of acting on them?
 Yes
 No *Proceed to question #5 regardless of response.*
5. Over the past month, have you started to work out or worked out the details of how to kill yourself?
 Yes *If 'Yes', proceed to question #6*
 No *If 'No', proceed to question #7*
6. If yes to Q5, at any time in the past month did you intend to carry out this plan?
 Yes
 No *Proceed to question #7 regardless of response.*
7. In your lifetime, have you ever done anything, started to do anything, or prepared to do anything to end your life (for example, collected pills, obtained a gun, gave away valuables, went to the roof but didn't jump)?
 Yes *If 'Yes', proceed to question #8*
 No *If 'No', proceed to scoring*
8. If yes to Q7, was this within the past 3 months?
 Yes
 No *Proceed to scoring*

Positive Columbia (C-SSRS):

*Yes to ANY ONE of the
following items:
3, 4, 5, 8*

VA Comprehensive Suicide Risk Evaluation Interview

- **Current Suicidality**
- **Suicide History**
- **Warning Signs**
- **Risk Factors**
- **Protective Factors & Reasons for Living**
- **Clinical Impressions**



THERAPEUTIC RISK MANAGEMENT

<https://www.mirecc.va.gov/visn19/trm/>

CHRONIC Therapeutic Risk Management – Risk Stratification Table



HIGH CHRONIC RISK

Essential Features

Common Warning Sign

- Chronic suicidal ideation
- Common Risk Factors
 - Chronic major mental illness and/or personality disorder
 - History of prior suicide attempt(s)
 - History of substance abuse/dependence
 - Chronic pain
 - Chronic medical condition
 - Limited coping skills
 - Unstable or turbulent psychosocial status (e.g. unstable housing, erratic relationships, marginal employment)
 - Limited ability to identify reasons for living



Action

These individuals are considered to be at chronic risk for becoming acutely suicidal in context of unpredictable situations (e.g., job loss, loss of relationship, relapse on drugs).

- These individuals typically require:
- routine mental health follow-up
 - a well-articulated safety plan means safety (e.g., no access to medication supply)
 - routine suicide risk screening
 - coping skills building
 - management of co-occurring symptoms

INTERMEDIATE CHRONIC RISK

Essential Features

These individuals may feature similar chronicity as those at high chronic risk with respect to psychiatric, substance abuse, medical and painful conditions.

Protective factors, coping skills, reasons for living, and relative psychosocial stability suggest enhanced ability to endure future crisis without resorting to self-directed violence.



Action

- These individuals typically require:
- routine mental health care to psychiatric condition and manage coping skills and protective factors
 - a well articulated safety plan means safety (e.g., no access to medication supply)
 - management of co-occurring symptoms

LOW CHRONIC RISK

Essential Features

These individuals may range from persons with no or little in the way of mental health or substance abuse problems, to persons with significant mental illness that is associated with relatively abundant strengths/resources.

Stressors historically have typically been endured absent suicidal ideation.

- The following factors will generally be missing:
- history of self-directed violence
 - chronic suicidal ideation
 - tendency towards being highly impulsive
 - risky behaviors
 - marginal psychosocial functioning



Action

Appropriate for mental health care on needed basis, some may be managed in primary care settings. Others may require follow-up to continue successful

ACUTE Therapeutic Risk Management – Risk Stratification Table



HIGH ACUTE RISK

Essential Features

- **Suicidal ideation with intent to die by suicide**
- **Inability to maintain safety independent external support/help**

Common Warning Signs

- A plan for suicide
- Recent attempt and/or ongoing preparatory behaviors
- Acute major mental illness (e.g., MDD episode, acute mania, acute psychosis, recent/current drug relapse)
- Exacerbation of personality disorder (e.g., increased borderline symptomatology)

Common Risk Factors

- Access to means
- Acute psychosocial stressors (e.g., job loss, relationship dissolution, relapse on alcohol)



Action

Typically requires psychiatric hospitalization to maintain safety and aggressively target modifiable factors.

These individuals need to be directly observed until on a secure unit and kept in an environment with limited access to lethal means (e.g. keep away from sharps, cords/tubing, toxic substances).

During hospitalization co-occurring psychiatric symptoms should also be addressed.

INTERMEDIATE ACUTE RISK

Essential Features

- **Suicidal ideation to die by suicide**
- **Ability to maintain safety, independent of external support/help**

These individuals may present similarly to those at high acute risk, sharing many of the features. The only difference may be lack of intent, based upon an identified reason for living (e.g. children), and ability to abide by a safety plan and maintain their own safety. Preparatory behaviors are likely to be absent.



Action

Consider psychiatric hospitalization, if related factors driving risk are responsive to inpatient treatment (e.g. acute psychosis).

Outpatient management of suicidal thoughts and/or behaviors should be intensive and include:

- frequent contact,
- regular re-assessment of risk, and
- a well-articulated safety plan

Mental health treatment should also address co-occurring psychiatric symptoms.

LOW ACUTE RISK

Essential Features

- **No current suicidal intent AND**
- **No specific and current suicidal plan AND**
- **No preparatory behaviors AND**
- **Collective high confidence** (e.g., patient, care provider, family member) in the ability of the patient to independently maintain safety

Individuals may have suicidal ideation, but it will be with little or no intent or specific current plan. If a plan is present, the plan is general and/or vague, and without any associated preparatory behaviors (e.g., "I'd shoot myself if things got bad enough, but I don't have a gun"). These patients will be capable of engaging appropriate coping strategies, and willing and able to utilize a safety plan in a crisis situation.



Action

Can be managed in primary care.

Outpatient mental health treatment may also be indicated, particularly if suicidal ideation and psychiatric symptoms are co-occurring.

When/when not to plan

- Individuals at **HIGH ACUTE RISK** (inability to maintain safety without direct observation) are not well-suited for safety planning
 - THOUGHTS here?
- Individuals at **LOW ACUTE** or **LOW CHRONIC** risk do not generally need safety plans, though previous plans can be reviewed and updated

CONSIDERATIONS for PLANS in SPECIFIC SETTINGS & POPULATIONS

- Emergency Departments
- Inpatient/Residential
- Individuals in Ethnic/Racial minority groups
- LGBTQ+
- Geriatric
- Adolescents

Emergency Departments

- KEY – If individuals are in high acute risk for suicide:
 - Safety Planning is not recommended
 - Hospitalization to stabilize
- For those with intermediate or lower acute suicide risk:
 - Seek to empower the individual, focusing on providing education of self-driven care and coping; use MI strategies to enlist the individual in this goal
 - Conduct assertive liaison work to schedule and connect to outpatient services
 - Work on lethal means reduction actively while in the ED
 - Follow-up with telephone check-ins to ascertain status and remind of appointments and check on client's efforts

Inpatient/Residential settings

- TRANSITIONS In levels of care (i.e., inpatient/residential to outpatient) is a critical time for suicidal individuals
 - Don't wait until right before discharge to plan
 - Plans need greater emphasis on family, friends and natural supports (such as peer supports/groups)
 - Initiate lethal means reduction with supports while on the unit
 - Foster warm hand-offs to outpatient services, linking patient to providers and groups ahead of time
 - Follow-up by telephone to ascertain status, review safety plan, remind of appointments, convey caring/concern

More on Inpatient/Residential Safety Plans

- Safety plans created inpatient may be less pertinent and precise
 - Ensure that outpatient providers revisit and renew these Safety Plans
 - Educate clients on this possible limitation
- Mentor clients about the goal of the safety plan as a living, breathing self-care plan
 - Where will it be kept?
 - How often will it be checked?
 - Who will you share your plan with?
 - Other thoughts here?

Safety planning considerations with Individuals in minority groups

- AT THE OUTSET – There is no cookbook for suicide prevention with individuals of different racial/ethnic groups
- **CULTURAL HUMILITY** is key:
 - Lifelong commitment to self-evaluation and self-critique
 - Redress power imbalances in the patient-clinician dynamic
 - Develop mutually beneficial and non-paternalistic clinical partnerships with individuals and communities

Actions to consider to bridge culture

- Tailor information and resources to respectfully address your target population's values, beliefs, culture, and language.
- Use alternative formats (e.g., audiotape, large print, storytelling) whenever appropriate.
- Create an open dialogue with group members to allow cultural considerations to be communicated, such as preferences regarding personal space, geography, familiarity, and terminology (i.e., words that should be used or avoided).

More on safety planning with those in the Ethnic/Racial Minority

- Building trust can be challenging given client's experiences in MH/medical settings in the past
 - May need to take more time in rapport building
 - Even more emphasis on listening and understanding
- Be open to non-linear ways of thinking, problem-solving, healing and approaching this task (e.g., Indigenous people)
- Family may play a more central in the plan (e.g., Latinx individuals)
- It is essential to communicate understanding of the sociocultural influences on symptoms and functioning

LGBTQ+

WHEN SAFETY PLANNING:

- Normalize adverse impact of minority stress
- Validate unique strengths and resilience of LGBTQ+ people
- Focus on supportive relationships and discuss ways to find/foster more accepting environments – work, church, community at large
- Ensure access to LGBT-affirming healthcare

LGBTQ+ Suicide Prevention Hotlines:

GLBT National Help
Center: 1-888-843-4564

The Trevor Project
(for LGBT and
questioning young
people up to age
24): 1-866-488-7386

Trans Lifeline:
1-877-565-8860

Geriatric populations

- In general, suicide attempts in seniors are more lethal
- Geriatric clients can be more isolated and less willing to ask for help
- Cognitive abilities need to be assessed
- Key adaptations:
 - Ensure understanding of the premise of plan and perception of choice
 - Work on goal of increasing social network
 - Encourage reaching out earlier in the plan before symptoms get too intense

Adolescents

- Greater focus on engaging parents, school, and community supports
 - Connect with school counselors as part of planning if possible
 - Clarify that the plan is to be shared
- Parental behavior change is essential for lethal means reduction
- Incorporate apps and social media supports:
 - SafeUT
 - My3
 - CalmHarm
 - Others?



Take-home messages

- Safety planning is an **evidence-based intervention** that saves lives
- Assess suicide risk to inform when to safety plan
- Proactive and educational approaches to safety planning are instrumental with transitions of care
- Be sensitive to the specific experiences, strengths and culture of specific populations

IF YOU ONLY HAVE TIME FOR ONE INTERVENTION

MAKE A SAFETY PLAN!

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